Anthem Blue Cross of California
Anthem Silver Pathway PPO 2000/25%

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 – 12/31/2016

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/ca/sbc or by calling (855) 383-7247.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** family for In-Network Providers. Does not apply to Preventive Care. **$5,000** person / **$10,000** family for Out-of-Network Providers.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$6,350** person / **$12,700** family for In-Network Providers. **$10,000** person / **$20,000** family for Out-of-Network Providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care This Plan Doesn't Cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Pathway - PPO. For a list of In-Network providers, see www.anthem.com/ca or call **(855) 383-7247**. Dental and Vision benefits may access a different network of providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 383-7247 to request a copy.

Important Questions	Answers	Why this Matters:
		plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit and then 25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	All office visit copayments count towards the same 3 visit limit. In Network Deductible is waived for the first 3 non-preventative visits combined for the following benefits: Primary Care Physician (PCP), Specialty Care Provider (SCP), other practitioner, retail health clinic, online care, Telehealth or acupuncture Office Visits; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder or autism

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				services; maternity postnatal care; outpatient Mental Health and Substance Abuse services or urgent care visits.
	Specialist visit	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
	Other practitioner office visit	$35 copay per visit and then 25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none-------- Deductible applies after first 3 non-preventive visits
	Preventive care/screening/immunization	No charge	50% coinsurance after the deductible is met	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 25% coinsurance after deductible is met X-Ray – Office after deductible is met 25% coinsurance	Lab – Office 50% coinsurance after deductible is met X-Ray – Office 50% coinsurance after deductible is met	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1 - Typically Generic	25% coinsurance after the deductible is met (retail and home delivery)	50% coinsurance after the deductible is met (retail only)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
http://www.anthem.com/pharmacyinformation/ Anthem Select Drug List				program). No coverage for non-formulary drugs.
	Tier 2 - Typically Preferred/ Brand	25% coinsurance after the deductible is met (retail and home delivery)	50% coinsurance after the deductible is met (retail only)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 3 - Typically Non-preferred/ Specialty Drugs	25% coinsurance after the deductible is met (retail and home delivery)	50% coinsurance after the deductible is met (retail only)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 4 - Typically Specialty Drugs	25% coinsurance after the deductible is met (retail and home delivery)	50% coinsurance after the deductible is met (retail only)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
	Physician/surgeon fees	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Emergency Room Physician Fee 25% coinsurance after the deductible is met Emergency Room Facility Charges $200 copay per visit and then 25% coinsurance after the deductible is met	Emergency Room Physician Fee Covered as In-Network Emergency Room Facility Charges Covered as In-Network	Emergency Room Physician Fee Cost share waived if admitted Emergency Room Facility Charges Copay waived if admitted
	Emergency medical transportation	25% coinsurance after the deductible is met	Covered as In-Network	--------none--------
	Urgent care	$50 copay per visit and then 25% coinsurance after the deductible is met	Covered as In-Network	Deductible applies after first 3 non-preventive visits
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
	Physician/surgeon fee	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $35 copay per visit and then 25% coinsurance after the deductible is	Mental/Behavioral Health Office Visit 50% coinsurance after the deductible is met Mental/Behavioral	Mental/Behavioral Health Office Visit Deductible applies after first 3 non-preventive visits Mental/Behavioral

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		met Mental/Behavioral Health Other Outpatient Items and Services 25% coinsurance after the deductible is met	Health Other Outpatient Items and Services 50% coinsurance after the deductible is met	Health Facility Other Outpatient Items and Services --------none--------
	Mental/Behavioral health inpatient services	Inpatient Facility Fee 25% coinsurance after deductible is met	Inpatient Facility Fee 50% coinsurance after deductible is met	Inpatient Facility Fee --------none--------
	Substance use disorder outpatient services	Substance Use Office Visit $35 copay per visit and then 25% coinsurance after deductible is met Substance Use Other Outpatient Items and Services 25% coinsurance after the deductible is met	Substance Use Office Visit 50% coinsurance after the deductible is met Substance Use Other Outpatient Items and Services 50% coinsurance after the deductible is met	Substance Use Office Visit Deductible applies after first 3 non-preventive visits Substance Use Other Outpatient Items and Services --------none--------
	Substance use disorder inpatient services	Inpatient Facility Fee 25% coinsurance after the deductible is met Inpatient Physician	Inpatient Facility Fee 50% coinsurance after the deductible is met Inpatient Physician	Inpatient Facility Fee --------none-------- Inpatient Physician Fee --------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		Fee 25% coinsurance after the deductible is met	Fee 50% coinsurance after the deductible is met	
If you are pregnant	Prenatal and postnatal care	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	In-Network preventive prenatal and postnatal services are covered at 100%.
	Delivery and all inpatient services	Inpatient Facility Fee 25% coinsurance after the deductible is met Inpatient Physician Fee 25% coinsurance after the deductible is met	Inpatient Facility Fee 50% coinsurance after the deductible is met Inpatient Physician Fee 50% coinsurance after the deductible is met	Inpatient Facility Fee Other cost shares may apply depending on services provided. Inpatient Physician Fee --------none--------
If you need help recovering or have other special health needs	Home health care	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per benefit period.
	Rehabilitation services	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
	Habilitation services	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 days per benefit period.
	Durable medical equipment	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
	Hospice service	25% coinsurance after the deductible is met	50% coinsurance after the deductible is met	--------none--------
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.
	Glasses	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.
	Dental check-up	No charge	No charge	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Non-Formulary drugs
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (855) 383-7247. You may also contact your state insurance department at:

Department of Managed Health Care
California Help Center
980 9th Street
Suite 500
Sacramento, CA 95814-2725
(888) HMO-2219

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Department of Managed Health Care
California Help Center
980 9th Street
Suite 500
Sacramento, CA 95814-2725
(888) HMO-2219

California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
http://www.healthhelp.ca.gov
helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does</u> provide minimum essential coverage.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm.Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover
medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,222
- **Patient pays** $3,318

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$35
Coinsurance	$1,283
Limits or exclusions	$0
Total	$3,318

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,951
- **Patient pays** $1,449

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,079
Copays	$70
Coinsurance	$0
Limits or exclusions	$300
Total	$1,449

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call (855) 383-7247 or visit us at www.anthem.com/ca

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